Benefit Choice Options

Local Government Health Plan

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2005 - June 30, 2006

Rod R. Blagojevich, Governor

Table of Contents

Important Changes For Fiscal Year 2006 effective July 1, 2005

Changes to the Local Care Health Plan (LCHP)

- **Family Out-of-Pocket Maximums:**
  - ⇨ Out-of-Network - $8,000
- **Emergency Room** Visit Deductible is $300
- The LCHP Preferred Provider Organization (PPO) Hospital network is subject to change each plan year. To review a complete list of participating hospitals, visit www.benefitschoice.il.gov .
- Prescription copayments have changed, see page 5 for details. The new Prescription Drug Plan Administrator is Medco Health Solutions. A new identification card will be sent in June.

Changes to Managed Care Health Plans

- The plans that were available last year continue to be available. Two plans have expanded their service areas. See page 11 for details.
- Home Health Visit Copayment of $20 per visit has been implemented. See page 10 for details.
- Retail Prescription Drug Benefits for all Managed Care Health Plans copayments are as follows: $9 - generic; $18 - preferred brand; and $36 non-preferred brand. The new Prescription Drug Plan Administrator is Medco Health Solutions for plan participants enrolled in HealthLink OAP or Health Alliance Illinois, see pages 5 & 6 for details. A new identification card will be sent in June.

Medicare Part D

- The Federal prescription drug plan benefit will be available January 1, 2006. Affected individuals will be contacted by their health plan administrator prior to the Medicare Part D Open Enrollment Period (November 2005).

Changes to Vision Care Benefit Program

- The new Vision Plan Administrator is EyeMed, see page 12 for details.
- No change to copayments.

Changes to Local Government Dental Plan (LGDP)

- Annual deductible is $100 for all covered services except preventive and diagnostic.
- Maximum benefit limit is now $2,000 per person, per plan year after plan deductible.

Your Responsibilities

Benefit Choice is May 1- May 31, 2005. It is the time to review and/or make changes to your health benefit plan. Benefit Choice is the only time, other than a qualifying change in status, that you can change health plans or add/drop dependent coverage. The changes made during this period will remain in effect for the plan year July 1, 2005 through June 30, 2006.

Steps to follow to make a Benefit Choice change:

1. **Read the information in this booklet.** It is your responsibility to know the benefit coverages and limitations. If necessary, obtain additional information on the plan in which you are currently enrolled or in which you are considering enrolling. Visit the benefits website at www.benefitschoice.il.gov for links to plan administrator websites.

2. Make your health plan choices. Review the features below to help you make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

You have three (3) types of medical plans from which to choose:

- Health Maintenance Organizations (HMO) - Managed Care Health Plan
- Open Access Plan (OAP) - Managed Care Health Plan
- Local Care Health Plan (LCHP) - Indemnity Plan

Managed care plans have geographic and provider limitations. If you are interested in a managed care plan, carefully review the information on pages 9 and 10 and the map of Managed Care Plans in Illinois Counties on page 11. Network provider directories are available on each plan administrator's website. The LCHP is available regardless of your place of residence.

Remember: There can be changes in your coverage even if you do not change plans. Specific questions regarding coverage should be directed to each respective plan administrator. Telephone numbers and web addresses are listed on page 13.

3. Complete the Benefit Choice Election Form that is located at the end of this booklet. Complete this form only if you want to make a change to your benefits. Submit the completed form to your Health Plan Representative (HPR) any time during the Benefit Choice election period that ends on May 31, 2005.

4. Review the Verification Statement that will be mailed to you from the Department of Central Management Services to confirm your Benefit Choice election changes. If you make Benefit Choice election changes, this statement will be sent to you after your request has been processed.

Changes to Your Benefit Elections During the Year.

You may change your benefit elections during the year only if you have a qualifying change in status (life event change) that affects your benefit needs. You have 60 days from the date of the qualifying change in status event to notify your HPR. **If the event would normally qualify the person for COBRA, failure to notify your HPR of changes that may affect eligibility for you or your dependents within the 60 day time period will disqualify the affected individual from COBRA continuation of coverage.** You must contact your HPR when one of the following events occur:

- You and/or your dependents have a change of address.
- You experience a life event change that may affect eligibility for you or your dependent(s) such as:
  - birth/adoption of a child (enrollment for a newborn is not automatic. Contact your HPR within 60 days of birth for coverage to be retroactive to the date of birth);
  - marriage, divorce, legal separation or annulment;
  - death of spouse or dependent;
  - employment status change for you, your spouse or your dependent(s) that affects eligibility under the program;
  - dependent(s) loss of eligibility;
  - court order resulting in the gain or loss of a dependent;
  - change in Public Aid recipient status; or,
  - dependent becomes covered by other group health or dental coverage.
- You or your enrolled dependents have other group insurance coverage including Medicare, or gain other coverage during the plan year. Provide a copy of the insurance or Medicare card to your HPR as soon as possible.

LGHP offers its Members valuable programs...

Vision Care Benefit Plan

Eye examinations are an important part of your overall health, protecting your visual wellness as well as providing early detection of serious health conditions. EyeMed is the new Vision Plan Administrator. See page 12 for more information.

Smoking Cessation Program

Members and dependents are eligible to receive a rebate toward the cost of an approved Smoking Cessation Program. The maximum rebate is $50 and is limited to one rebate per plan year. See your Benefits Handbook for details.

COBRA

Established under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), eligible employees, their spouses and dependent children enrolled in a CMS-administered group health plan may purchase continued health and dental coverage if their group health coverage terminates for specific reasons called "qualifying events". For detailed information regarding COBRA, see your Benefits Handbook or contact your employing unit's HPR.

Frequently Asked Questions (FAQs)

Q. Who do I contact for more information about my benefits or to make changes to my existing coverage?
A. Contact the HPR at your employing Unit. Your Unit's personnel or payroll office can assist you in locating your HPR.

Q. Do I get a new medical and prescription drug identification card every plan year?
A. The only times you will receive an identification card are when you first enroll in the plan, if you change plans, if the plan administrator changes or if you request new cards. If you lose your identification card(s), you may request a replacement card(s) from your Medical and Prescription Drug Plan Administrator listed on page 13. As the plan administrator for the prescription drug program has changed for LCHP, Health Alliance Illinois and HealthLink OAP, plan participants enrolled in any of these plans will receive a new prescription drug identification card from Medco.

Q) Is enrollment for my newborn for health coverage automatic?
A) **No, enrollment for a newborn is not automatic.** To enroll a newborn, contact your HPR within 60 days of birth for coverage to be retroactive to birth. The newborn's birth certificate is required for enrollment.

Q) What should I, or my dependent, do when we turn 65 or become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD)?
A) In most cases, you must enroll in both Medicare Parts A and B and send a copy of your Medicare card to your HPR. If you or your dependent are actively working and eligible for Medicare or you have additional questions about this requirement, contact the Group Insurance Division, Medicare COB Unit. See page 13 for information.

Q) My address has changed. What should I do?
A) Contact your HPR as soon as possible to update your insurance records.

For Plan Participants currently enrolled in or considering enrollment in the Local Care Health Plan (LCHP), Health Alliance Illinois or HealthLink OAP:

Q) How do I order medications through Medco's Mail Order Pharmacy?
A) To order from Medco's Mail Order Pharmacy, you must obtain an original 61-90 day written prescription plus up to three 61-90 day refills from your doctor and complete a Mail Order Form available at www.benefitschoice.il.gov . Send the original prescription, the completed Mail Order Form and the appropriate copayment to Medco at the address listed on the form. Your prescription should be shipped within 11 days.

Q. How do I order refills through Medco's Mail Order Pharmacy?
A. Once enrolled, you will receive a refill form from Medco with each mail order prescription. For quicker processing, you can also order refills via the Internet or by telephone. Visit Medco's website at www.Medco.com or call Medco at (800) 899-2587.

Prescription Drug Plan for Local Care Health Plan (LCHP), Health Alliance Illinois and HealthLink OAP Managed Care Health Plans

Medco Health Solutions is the new Prescription Benefit Manager (PBM) for participants enrolled in the above-named plans. If you are not enrolled in one of the above mentioned health plans, contact your Managed Care Plan for prescription information. The coverage provides both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or a dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription. When a brand drug is dispensed for any reason, and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment.

The prescription benefit includes a Preferred Drug List. This list is available by calling Medco at (800) 899-2587, or at www.benefitschoice.il.gov . The Preferred Drug List is subject to change at any time during the plan year. If you are currently taking a medication that is not on Medco's Preferred Drug List, you will receive a letter informing you of the Medco preferred alternative drug. Please review this letter with your physician to determine if a change in your prescription is appropriate.

Medco is working with Caremark to transfer open mail order prescriptions. Certain prescriptions can not be transferred. Therefore, you may need to obtain a new prescription. If so, you will be notified. The prescription plan offers several options:

Benefit Type Available	Dispensing Facility	Type and Supplies
Retail Pharmacy Network	Retail Pharmacy*	1 to 30-day fill of medication for one copay. 31 to 60-day fill for two (2) copays.
Mail Order Pharmacy	Mail Order Pharmacy	61 to 90-day supply of medication.
Out-of-Network Benefit	All Pharmacies	In most cases, the cost of the prescription drugs will be higher when not using an in-network pharmacy or the mail order pharmacy. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from Medco) and your original prescription receipt. However, reimbursement will be at the applicable brand or generic in-network copayment.
***Contact your retail pharmacy to see if it is participating in the Retail Pharmacy Network.**		

Retail Pharmacy Network

This network of retail pharmacies contracts with Medco to accept certain copayment amounts. There are no plan year deductibles and no claim forms to file.

Medication (1-30 day supply):

Generic	$ 9.00
Preferred Brand	$18.00
Non-preferred Brand	$36.00

Medication (31-60 day supply):

Generic	$18.00
Preferred Brand	$36.00
Non-preferred Brand	$72.00

Maximum days supply at one fill is 60 days.

Medco Mail Order Pharmacy

The mail service program provides up to a 90 day supply of medication for the cost of a 31-60 day supply. There are no plan year deductibles.

61 to 90-day supply:

Generic	$18.00
Preferred Brand	$36.00
Non-Preferred Brand	$72.00

To receive a discounted 61 to 90-day supply of medication, obtain an original prescription from the attending physician written for a 61 to 90-day supply plus up to three (3) 90-day refills, totaling one year of medication. If ordering through Medco's mail order pharmacy, complete the mail order form. The original prescription must be attached to the order form and mailed to the mail order pharmacy. Medication should be delivered within 11 days from the time mail order pharmacy receives the order.

Out-of-Network Benefit

Prescription drugs may be purchased at out-of-network pharmacies. Reimbursement will be at the applicable brand or generic in-network price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs will be higher when not using in-network pharmacies. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from Medco) and the original prescription receipt.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans; the appropriate copayment will be applied for each prescription filled.

Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

Behavioral Health Services

LCHP

Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are administered through the LCHP Behavioral Health Administrator listed on page 13. Calling the Behavioral Health Administrator begins the authorization process for services with all levels of care to avoid penalties or non-authorization of benefits. All behavioral health services are subject to medical necessity. Eligible charges are for those services deemed medically necessary by the Behavioral Health Administrator. Services determined not medically necessary will not be eligible for coverage. For further information regarding benefit coverage, coordination of benefits and authorization requirements, refer to the Benefits Handbook.

Managed Care Health Plans

Managed care plans determine the maximum number of inpatient days and outpatient visits for mental health and/or substance abuse treatment. Plan benefits may vary, but a minimum of 10 inpatient days and 20 outpatient visits are required. These are in addition to detoxification benefits which include diagnosis and treatment. For further information, contact the respective Managed Care Health Plan Administrator listed on page 13.

NOTICE OF PRIVACY PRACTICES

For Individuals Enrolled in the Local Care Health Plan (LCHP) and the Local Government Dental Plan (LGDP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act including the LCHP and the LGDP. The term "we" in this Notice means the Bureau and our Business Associates (health plan administrators).

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices concerning your PHI. For uses and disclosures not covered by this Notice, we will seek your written authorization. You may revoke an authorization at any time; however, the revocation will only affect future uses or disclosures.

The Bureau contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. You may not have coverage with all of the Business Associates. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on behalf of the Bureau in performing their respective functions. When we seek help from individuals or entities who are not part of the Bureau in our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule. CIGNA HealthCare is the Medical Plan Administrator. Intracorp (a CIGNA HealthCare Affiliate) is the Notification and Medical Case Management Administrator. Medco Health Solutions is the Prescription Drug Plan Administrator. Magellan Behavioral Health is the Behavioral Health Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a notice from the HMO regarding its privacy practices.

How We May Use or Disclose Your PHI:

Treatment: We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party. We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.
Payment: We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.
Health Care Operations: We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.
Appointment Reminders: Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

Legal Requirements:

We may use and disclose PHI **as required or authorized by law**. For example, we may use or disclose your PHI for the following reasons.

Public Health: We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.
Health Oversight Activities: We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.
Judicial and Administrative Proceedings: We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your authorization to disclose your PHI.
Law Enforcement: We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.
Avert a Serious Threat to Health or Safety: We may use or disclose PHI to stop you or someone else from getting hurt.
Work-Related Injuries: We may use or disclose PHI to workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.
Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.
Organ Procurement: We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.
Release of Information to Family Members: In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.
Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.
National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.
Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.
Research: You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an authorization form must be signed.
Fundraising and Marketing: We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

Plan Sponsors: Your employer is not permitted to use PHI for any purpose other than the administration of your benefit plan. If you are enrolled through a unit of local government, we may disclose summary PHI to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate.

Illinois Law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless Illinois law allows us to make the specific type of use or disclosure without your authorization.

Your Rights:

You have certain rights under federal privacy laws relating to your PHI. To exercise these rights, you must submit your request in writing to the appropriate plan administrator. These plan administrators are as follows:

For the Medical Plan Administrator and Notification/Medical Case Management:

CIGNA HealthCare, Privacy Office
P.O. Box 5400
Scranton, PA 18503
800-762-9940

For Pharmacy Benefits:

Medco Health Solutions, Privacy Services Unit
P.O. Box 800
Franklin Lakes, NJ 07417
800-987-5237

For Behavioral Health Benefits:
Magellan Behavioral Health, Privacy Officer
1301 E. Collins Blvd.
Suite 100
Richardson, TX 75081
800-513-2611

For Dental Plan Benefits:
CompBenefits, Privacy Officer
100 E. Mansell Court E.
Suite 400
Roswell, GA 30076
800-342-5209

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home or that we send your mail to another address. If your request is put in writing and is reasonable, we will accommodate it. If you feel you may be in danger, just tell us you are "in danger" and we will accommodate your request.

Inspect and Access: You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. If you ask us to mail your records, we may also charge you a fee for mailing the records.

Amendment of your Records: If you believe there is an error in your PHI, you have a right to make a request that we amend your PHI. We are not required to agree with your request to amend. We will send you a letter stating how we handled your request.

Accounting of Disclosures: You have a right to receive an Accounting of Disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or disclosures made pursuant to your authorization. We may charge you a fee if you request more than one Accounting in a 12-month period.

Copy of Notice and Changes to the Notice: You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, you will receive a new Notice within sixty (60) days of the material change. You can also access a revised Notice on our website at "http://www.state.il.us/cms/2_servicese_ben/privpracs.htm".

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer of the respective Plan Administrator. If the Privacy Officer does not handle your complaint or request adequately, please contact the Central Management Services, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C. if you feel your privacy rights have been violated.

EFFECTIVE DATE: July 1, 2005

Health Plan Options

Review the features below to help make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

There are three (3) types of medical plans from which to choose:

Plan	Type	Features
Health Maintenance Organizations (HMO)	Managed Care	•Selection of primary care physician (PCP) •Referrals to specialists often controlled by PCP •Lower out-of-pocket costs
Open Access Plan (OAP)	Managed Care	•Selection of PCP with self-referral to specialists •Out-of-network physician and hospital access •Slightly higher out-of-pocket costs
Local Care Health Plan (LCHP)	Indemnity Plan	•Access to any physician •Higher out-of-pocket costs

Managed Care Health Plans

There are 7 managed care plans. Plans include HMOs and an OAP. All offer comprehensive benefit coverage.

There are distinct advantages to selecting a managed care health plan – namely, lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and limited provider networks. If you are considering a managed care plan, explore and research the various plans available. Benefits are subject to the limitations outlined in each plan's Summary Plan Document. Contact the managed care plan administrator for detailed information concerning the various levels of coverage provided. See page 13 for Plan Administrator information.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Plan participants select a Primary Care Physician (PCP) from the network of participating providers. In conjunction with the health plan, the PCP directs all healthcare services for the plan participant, including visits to specialists and hospitalizations. When medical services are coordinated through the PCP, the plan participant pays only a predetermined copayment. There are no annual plan deductibles for HMO plans.

Open Access Plan (OAP)

The plan is unique because it offers three benefit levels:

Tier I - HMO level of benefits - often paying 100% after a copayment (using a Tier I network provider).
Tier II - self-referral PPO benefits generally paying at 90%, after you pay a deductible (using a Tier II network provider).
Tier III - open access to out-of-network providers where benefits are generally paid at 80% of the usual and customary charges (after a deductible).

Your benefit level is determined by the provider you choose. The plan provider directory contains separate listings of participating providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive.

Local Care Health Plan (LCHP)

LCHP is a medical indemnity plan which offers a comprehensive range of benefits. The LCHP Medical Plan Administrator is CIGNA. Under LCHP, you choose any physician or hospital for general or specialty medical services, and receive higher levels of benefits by using a LCHP Preferred Provider Organization (PPO) hospital or the CIGNA Healthcare PPO Network of providers and facilities. Intracorp is the LCHP Notification Administrator/Medical Case Management Administrator. In addition to the State's PPO hospital network, LCHP non-Medicare members also have access to CIGNA's nationwide network of PPO hospitals and medical providers. An enhanced 90% benefit for hospital services, facility services, and professional fees is available by using a network provider. The network providers are reimbursed on the basis of a negotiated rate and usual and customary limits are not applied to the enrollee. To receive the enhanced PPO network benefit, always present your LCHP identification card with the CIGNA logo at the time of service. Magellan Behavioral Health is the LCHP Behavioral Health Administrator for mental health/substance abuse services. Contact Magellan for a listing of network providers and facilities. Medco Health Solutions is the Prescription Drug Plan Administrator. See page 13 for Plan Administrator information.

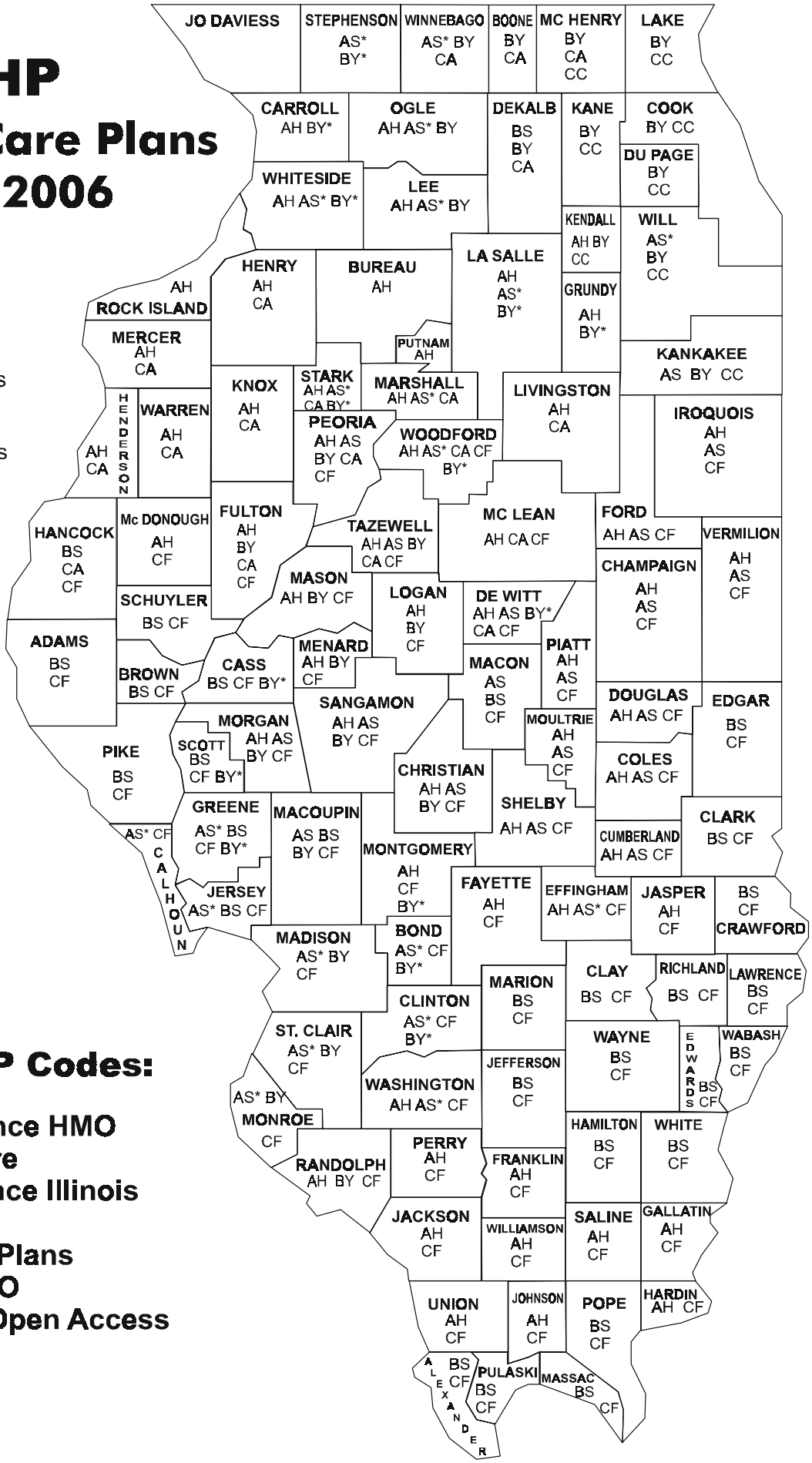
Health Plan Comparison

Benefit	LCHP	HMO	OAP Tier I	OAP Tier II	OAP Tier III (Out-of-Network)
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000
Patient Responsibilities					
Annual Out-of-Pocket Maximum • Per Enrollee • Per Family	**General:** $1,000 per enrollee $2,500 per family/plan year **Non-PPO Hospital:** $4,000 per enrollee $8,000 per family/plan year	$1,500 $3,000	Not Applicable	$1,000 $2,500	$2,000 $5,000
Other Deductibles/Copayments: **Emergency Room** **Non-PPO/Out-of-Network Hospital Admission**	$300 $250	$150 No Coverage	$150 See Tier III for benefit level	$150 + 10% Network Charges** See Tier III for benefit level	$150 + 20% Network Charges** $350 + 20% of U&C*
Annual Plan Deductible Must be satisfied for all services	$250 Per Enrollee	$0	$0	$300 Per Enrollee	$500 Per Enrollee
Plan Benefit Levels Comparison*					
Inpatient	90% - PPO 80% or 65% - Non-PPO	$200 copayment	$200 copayment	90% of network charges** after $250 copayment	80% of U&C* after $350 copayment
Outpatient Surgery	90% for PPO Network Provider	$150 copayment	$150 copayment	90% of network charges** after $150 copayment	80% of U&C* after $150 copayment
Diagnostic Lab & X-ray	80% of U&C*	100%	100%	90% of network charges**	80% of U&C*
Durable Medical Equipment	80% of U&C*	80% of network charges**	80% of network charges**	80% of network charges**	80% of U&C*
Physician Office Visit	90% PPO 80% of U&C* Non-PPO	$20 copayment	$20 copayment	90% of network charges** after a $20 copayment	80% of U&C*
Preventive Services	80% or 100% for specific services	$20 copayment	$20 copayment	90% of network charges** after a $20 copayment	Covered In-Network only
Home Health Care (Skilled Care Visits)	80% of U&C*	$20 copayment	$20 copayment	90% of network charges** for covered services	Covered In-Network only

*Usual & Customary (U&C) is an amount determined by the health plan administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment, or supplies for a similar medical condition.
**Network Charges are the amount the plan determines is the appropriate charge for a covered service.

LGHP
Managed Care Plans For FY 2006

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their codes appear.



*** If an asterisk appears by one of the managed care plans, it means the plan is new to that county.**

HMO and OAP Codes:

AH = Health Alliance HMO
AS = PersonalCare
BS = Health Alliance Illinois
BY = HMO Illinois
CA = OSF Health Plans
CC = UniCare HMO
CF = HealthLink Open Access

Local Government Dental Plan (LGDP)

All members are automatically enrolled in LGDP. LGDP is administered by CompBenefits. Under LGDP, you may go to any dentist and receive benefits for an extensive range of services. LGDP reimburses covered services at a pre-determined maximum allowable scheduled amount. Members are responsible for any charges over the scheduled amount. For a detailed description of your dental plan benefits, see the schedule of benefits at www.benefitschoice.il.gov . Dental plan questions should be directed to CompBenefits, at (800) 999-1669, or (312) 829-1298 (TDD/TTY).

Plan Design	Local Government Dental Plan (LGDP)
Annual Deductible	$100 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefits.
Maximum Benefit Limit	$2,000 per person per plan year after plan deductible.
Maximum Benefit Level for Child Orthodontics (under age 19)	$1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above. **Contact CompBenefits for a pre-treatment estimate.**
Claim forms	Required
Dentist selection	Choice of provider

Vision Care Benefit Plan

The Vision Care Benefit Plan is designed to assist with the costs of well vision care. Eye examinations can provide early detection of serious health conditions throughout the entire body. The Plan is intended to encourage regular eye examinations and assist with vision care expenses when glasses or contact lenses are needed.

All Members and dependents covered by any of the health plans offered by the Local Government Health Plan are eligible for the Vision Care Benefit Plan. The eye exam benefit and materials such as frames, spectacle lenses or contact lenses (in lieu of frames and spectacle lenses) are available once every 24 months.

The new Vision Plan Administrator is EyeMed. Benefits are available from both in-network and non-network providers. Visit www.benefitschoice.il.gov for a link to EyeMed's website for the most up to date listing of network providers. See your Benefits Handbook for benefit details or contact EyeMed at (866) 723-0512.

Service	Network Provider Benefit	Non-Network Provider Benefit
Eye Exam	$10 copayment	$20 Allowance
Spectacle Lenses (single, bifocal and trifocal)	$10 copayment	$20 Allowance for single vision lenses $30 Allowance for bifocal and trifocal lenses
Standard Frames	$10 copayment for frames within the benefit selection	$20 Allowance
Contact Lenses All contact lenses are in lieu of standard frames and spectacle lenses.	$20 copayment for medically necessary $50 copayment for elective contact lenses (hard, soft daily wear and gas permeable) $70 allowance for all other lenses not mentioned above	$70 Allowance

Who to call for information...Plan Administrators

Healthcare Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Web Site Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356, ext 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
OSF Health Plan	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org
Unicare HMO	(888) 234-8855	(312) 234-7770	www.unicare.com

Plan Component	Contact For:	Plan Administrator's Name and Address	Customer Service Phone Numbers and Web Site Address
Local Care Health Plan (LCHP) Medical Plan Administrator	Medical service information, claim forms, ID cards, claim filing/resolution, and pre-determination of benefits.	**CIGNA** Group Number 2457474 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services. Non-compliance penalty of $400 applies.	**Intracorp, Inc.** (no address required)	(800) 962-0051(nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator	Information on prescription drug coverage, pharmacy network, mail order drug, specialty pharmacy, ID cards and claim forms filing.	**Medco** Group Number: 1401, 1401BS, 1401CF **Paper Claims:** Medco Health Solutions P.O. Box 2080 Lee's Summit, MO 64063-2080 **Mail Order Prescriptions**: Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) **Prior to July 1, 2005:** www.benefitschoice.il.gov **After July 1, 2005:** www.medco.com
LCHP Behavioral Health Administrator	Notification,authorization, claim forms and claim filing/resolution for behavioral health services.	**Magellan Behavioral Health** Group Number 2457474 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Local Government Dental Plan (LGDP) Administrator	Dental services, claim forms, ID cards and filing.	**CompBenefits** Group Number 960 P.O. Box 4721 Chicago, IL 60680-4721	(800) 999-1669 (nationwide) (312) 829-1298 (TDD/TTY) www.compbenefits.com
Vision Plan Administrator	Vision services, benefits, network providers, claim forms and filing.	**EyeMed Vision Care** Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (nationwide) (800) 526-0844 (TDD/TTY) www.benefitschoice.il.gov
General Information	General information on the local government health plans, Medicare COB or other benefits.	**CMS Group Insurance Division** P.O. Box 10105 201 E. Madison Street Springfield, IL 62791	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)

Local Government Health Plan
BENEFIT CHOICE ELECTION FORM
May 1 – May 31, 2005 (Changes effective July 1, 2005)
COMPLETE THIS FORM ONLY TO MAKE A *CHANGE* IN YOUR BENEFITS

SECTION A: EMPLOYEE INFORMATION (required)

SSN: ___ ___

Last Name	First Name	Phone Numbers	
		Home:	Work:

SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)

(1) If you are changing to a managed care plan from the Local Care Health Plan (LCHP), or if you are changing to a different managed care plan, you must enter the Primary Care Physician (PCP) or National Provider Identifier (NPI) number.

(2) If you have Medicare or other insurance, you must give your Health Plan Representative (HPR) a copy of your Medicare/other insurance card.

HEALTH PLAN ELECTION	**If Managed Care is selected <u>you must</u> complete the information below. Go to the provider's website to find the physician's PCP or NPI number.** See the instruction sheet for more information.
Elect One:	PCP or NPI # _____ (maximum 10 digits)
Local Care Health Plan (LCHP) ☐	Carrier Code _____ (2 alpha characters)
~ Or ~	Plan Name _____
Managed Care: ☐ HMO or ☐ OAP	

SECTION C: DEPENDENT INFORMATION (dependent must enroll in the same plan as the member)

(1) You must provide documentation to <u>add</u> dependents – see the instruction sheet for specific documentation requirements.

(2) If the dependent has Medicare or other insurance, you must give your HPR a copy of the Medicare/other insurance card.

(3) If you are changing to a managed care plan from the LCHP, or if you are changing to a different managed care plan, you must enter the PCP or NPI number for each dependent in your plan.

A (Add) / D (Drop) / C (Change)			Name	SSN	Birth Date	Relationship *	PCP/NPI
A	D	C					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					

* Spouse, son, daughter, stepchild, adopted child

This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

HPR SIGNATURE: _____ DATE: _____

Give completed form to your HPR in your Unit by <u>May 31, 2005</u>.

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

If you are keeping your current coverage elections, you do not need to complete this Benefit Choice Election Form.

SECTION A – EMPLOYEE INFORMATION:

Complete all fields.

SECTION B – HEALTH PLAN ELECTION:

Do not complete this section if you only want to change your PCP – you must contact the managed care plan directly in order to make this change.

If you wish to change your **health** plan, you must check either the Local Care Health Plan (LCHP) or one of the managed care plan boxes (HMO or OAP). If electing/changing managed care plans, you must enter the managed care plan's two-digit carrier code (see page 11 of the FY2006 Benefit Choice booklet for carrier codes), the plan's name, and the Primary Care Physician (PCP) number or National Provider Identifier (NPI). The PCP or NPI number may be found in the online directory on the individual plan's website (see page 13 of the FY2006 Benefit Choice booklet for the Plan Administrator contact information).

SECTION C – DEPENDENT INFORMATION:

Complete this section if you are adding or dropping health coverage for a dependent. If you are adding dependent health coverage, **you must provide the appropriate documentation as indicated below:**

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child's parent, and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19, 2) a diagnosis from a physician with an ICD-9 diagnosis code, and 3) a statement from the Social Security Administration with the Social Security disability determination.
* The Dependent Coverage Certification Statement (CMS-138) is available from your HPR.	

SIGNATURE:

You must sign and date the Benefit Choice Election Form and give to your HPR by **May 31, 2005** in order for your elections to be effective July 1, 2005. Dependent documentation must be submitted to your HPR within 10-days of the end of the Benefit Choice Period. If documentation is not provided within the 10-day period your dependents will not be added.

Illinois Department of Central Management Services
Bureau of Benefits
PO Box 10105
Springfield, IL 62791

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